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ABSTRACT

The objective of this paper is to evaluate a model of intervention which can be easily developed and implemented in agencies that deal with multi-generational families. It is based on the realization that increases in the aged population highlight the need for supportive services to adult children. A sample of 35 adult children whose aged parents were awaiting admission into a long-term care facility convened for six weekly sessions. The program was designed to blend two modes of intervention: a therapeutic component and an educational one which provided pragmatic information. Results indicated that without exception group satisfaction was high. Therapeutically, this model provided members the opportunity to ventilate feelings, explore alternatives, and assess existing attitudes. On a didactic level, the learning gained helped participants understand the aging process, and facilitated effective use of community resources. The following implications emerged: the program is a good method for disseminating information and providing support to a population faced with common problems, and can be easily implemented in a wide variety of existing community settings. Further analysis is currently in progress to determine the effect of other variables on the coping ability of this population. (Author)

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A DIDACTIC AND THERAPEUTIC MODEL OF INTERVENTION IN WORKING WITH ADULT CHILDREN OF AGED PARENTS.

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A DIDACTIC AND THERAPEUTIC MODEL OF INTERVENTION FOR WORKING WITH ADULT CHILDREN OF AGED PARENTS

> One of the most unhappy times in the life of any human being comes when he must make the decision to institutionalize a parent.

Stanley Cath, (1972) in this poignant statement, brings to to light the hardships faced by many adult children who have no other alternative but to consider institutionalization of one kind or another for their elderly mother or father. This period of decision-making has been termed the filial crisis, or the stage during which the child can no longer look to the parent for support in times of emotional trouble or economic stress. The child, then, must assume the responsibility for looking after his dependent parent, and thus takes on the filial role, which if successfully performed, leads to filial maturity, or the capacity to be depended upon. (Blenkner, 1965.) This stage can be characterized by feelings of guilt, anxiety, depression, resentment and anguish. During this trying time, families often approach social agencies, physicians and the clergy for guidance and support.

Existing family agencies and hospitals, however, have not adequately incorporated into their structure services geared to meet the ever-increasing needs of these adult children. (Kahn & Silverman, 1976.) Is it not the responsibility of those agencies which deal with the geriatric population to also provide supportive services to those family members, for they constitute the primary source of support to their vulnerable parents?

Contrary to popular belief, ties between children and their aging parents continue to be viable and strong. (Sussman, 1965.) Most recent studies have shown that the isolated nuclear family is not the predominant structure in society today. What is most commonly found is the modified extended kin family. Litwack describes this structure as a family system with complicated networks of aid and service activities in which nuclear units are linked together both vertically and horizontally in order to exchange significant services. (Litwack, 1965.) The implication of such evidence for practice is clear. By practitioners regarding the aged population as the sole target for service, they are overlooking other components of the modified extended family, such as the children. By recognizing the interdependence that exists between parents and children, it can be assumed that by influencing one component of the system, the other parts will be affected.

The Department of Social Work at Maimonides Hospital & Home for the Aged in Montreal, a chronic geriatric hospital, has long since recognized the responsibility that children feel toward their parents. Due to the lengthy waiting period for admission, the family members often accommodate their ailing parent in an alternate facility which generally does not provide adequate care.[1]

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1. Government subsidized chronic care facilities in the Montreal Jewish community are few. The total bed capacity equals 410, of which 237 are located at Maimonides Hospital & Home for the Aged. Being the most modern of the three chronic care facilities and being located within the heart of the Jewish community, the hospital is a highly desirable placement for the chronically-ill elderly. The hospital receives 30 new applications per month of which 20 are accepted to a waiting list. Over the past five years, this waiting list has grown to the point where new applicants must now await from 2½ to 4 years for admission. This list now totals 450 persons 65 years of age and over who require chronic care.

The traditional approach utilized to deal with the needs of the adult child, who has a parent living either in an institution or in the community, has been that of casework on an individual basis. What has become evident from contact with families are the striking similarities in the situations and concerns of these family members who have parents awaiting admission. With this realization, a group work approach was seen as another means of servicing this population. It was hypothesized that adult children in similar circumstances could be mutually supportive of one another. The healing powers inherent in a group come into play when members can share their painful feelings, find others 'in the same boat' and begin to mobilize their strengths. (Shulman, 1971.) On this premise, a group based on a therapeutic and didactic model was initiated to meet the needs of these adult children. It was felt that such a medium would provide participants the opportunity to share common concerns and conflicts as well as offer them a knowledge base for further understanding of the aging process.

Description of Group Participants & their Parents:

Family members of applicants were invited to attend a series of six weekly sessions focusing on the problems of having a chronically ill parent. A total of 30 persons expressed initial interest. The actual attendance, however, was 23. Through a questionnaire, the following data was compiled. The group was comprised of 4 married couples, 2 sets of siblings and 9 individual children, representing 17 applicants on the waiting list. The greatest proportion of people were between the ages of 55 and 64. All but one were Canadian born. Of the 16 women, 43% were in the labour force and 57% were housewives. Of 7 men, 28%

were professional, the rest non-professionals. The data indicated that the majority of group members were from the lower and upper middle-class brackets.

Of the 23 participants, 60% felt that their parent needed the services of Maimonides Hospital to meet the need for physical supervision such as good nursing and medical care; 31% cited mental deterioration as the reason for application, and 9% felt that their parent needed stimulation and other social activities.

Of the 17 applicants represented, 35% lived in their own home. 29% lived with a family member; 24% resided in a nursing home; and 11% were in other facilities. All of these applicants were suffering from one or more chronic conditions.

Objectives of the Group:

By offering a combination of didactic material and a therapeutic milieu, various objectives were achieved.

1. to increase knowledge of the aging process; e.g. the psycho-social and physiological aspects;
2. to familiarize members with resources in the community which provide services for the aged;
3. to help members differentiate between the myths and realities of institutionalization;
4. to sensitize members to the needs and behaviours of their parents;
5. to provide a non-threatening milieu where members could ventilate and be mutually supportive.
6. to facilitate problem-solving around issues involving themselves, their families and their parent;

7. to discuss the attitudes, coping mechanisms and emotional responses of the participants to ameliorate the inter-generational relationships;

8. to familiarize members with the institution for which their parent was awaiting placement;

9. to allow members to socialize informally during the evening's coffee break;

Group Content:

At the opening session, group participants were given the opportunity to develop an agenda from what they viewed to be their own felt concerns and interests. The following outline emerged as a guideline for future sessions.

1. Description of facilities at Maimonides Hospital & Home for the Aged.
2. Community resources
3. The aging process
4. The pros and cons of institutionalization
5. Feelings and attitudes

The foremost concern of the participants at the onset of the sessions was to learn about the services offered at Maimonides Hospital & Home for the Aged, as well as existing community resources.

Satisfied that the group had sufficient information on these two subjects, the group leaders then introduced the next topic of concern, that of the process of aging. This area was discussed from a physical and psycho-social perspective. The group was informed about the most common ailments of old age such as diabetes, heart disease, arteriosclerosis, organic brain syndrome and Parkinson's Disease.

There was an obvious lack of understanding amongst group members of the behaviour related to psychological changes in the elderly. Children failed to comprehend peculiar symptoms exhibited by their parents such as paranoia, aggressiveness, agitation, fearfulness and disorientation. Through didactic material members were able to learn about the origin of these behaviours and subsequently developed a better understanding of what to expect and how to deal more effectively with a disturbed parent.

The myths and realities of institutional living were the next items on the agenda. The group explored what they believed to be the positive and negative aspects of institutional care. Members felt that their parent would benefit from the medical, nursing, and rehabilitative services offered in a good institution such as Maimonides Hospital & Home for the Aged. As well, they saw the institution as a place in which their parent would socialize with others their own age and benefit from structured activities. The children felt that placement at Maimonides Hospital & Home for the Aged would relieve them of the physical, emotional and financial burdens that they were presently experiencing.

In addition to the positive aspects expressed, members had already developed some sense of the harsh realities of institutional living. The issues of depersonalization, the fostering of dependency, the loss of dignity, and the routinization of daily life were examined.

The discussion on this topic terminated with a feeling of depression by the participants. However, members felt that they gained

Further insight into the realities of institutional living and hopefully their expectations of institutional care were more reasonable.

The discussion of institutionalization was a stepping stone to the exploration of feelings related to having a chronically-ill parent. In order to promote discussion on this sensitive subject, the group leaders presented certain statements as catalysts for discussion.[1] These were:

> 1. I am afraid that by placing my parent in an institution, he/she will not be getting the care that he/she was accustomed to. This instills guilt and anxiety in me.
>
> 2. I am finding it increasingly more difficult to cope with the responsibility placed upon me by my aging parent on one side and by my own family on the other.
>
> 3. Being faced with my aged parent makes me feel _____(fill in the blank and discuss.)
>
> 4. At times I wish my parent would die. This thought instills guilt in me.

These statements allowed group members, many for the first time to ventilate, look at and understand their feelings. The predominant theme resulting from an exploration of the first attitude was the guilt associated with the fear of deterioration of the parent once institutionalized. Similar feelings of guilt were provoked by the second statement. People felt caught between the demands of their parents and their immediate nuclear family. They expressed the guilt instilled in them when forced to choose between their parent

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1. These statements were modified from the article entitled "Issues and Ideas at Isabella." A Symposium on Attitudes: Fears and Guilts Surrounding Placing an Elderly Person in a Facility for the Aging. Isabella Geriatric Centre, New York.

or their spouse. Members regarded the setting of limits with their parents and the delineation of priorities as means of alleviating the stress associated with this unbearable situation. Learning was also effected by listening to others who had already experienced such difficulties.

The third statement allowed people to explore how they felt about being faced with an aged parent. Various emotions were expressed. The majority of persons felt frustrated, helpless, angry, resentful, anxious and nervous. Some conveyed sorrow for themselves and envy for others who were not in that situation. There was an expression of sadness in remembering the parent in his younger years as compared to his present dependent state. The fear of growing old themselves was a theme pervasive in the discussion. Most members concluded that they felt physically and emotionally trapped by their parent's situation.

The final statement dealt with the death-wish. Initially it was difficult for members to reveal their true feelings on this taboo subject. However, as members began to admit that they wished their parents would die, especially when their parent had expressed similar feelings, others in the group felt safe in verbalizing suppressed thoughts of the same kind. The death of a parent was seen as a relief not only for the burdened child, but also for the ailing parent.

The Composition of Didactic and Therapeutic Content:

Within the context of a group milieu, didactic learning and a therapeutic process occured. Learning was facilitated by written material, films, and a guest geriatrician.

Goldfarb's theory of intrapsychic evolution of disturbed and disturbing behaviour in the aged was used as a framework for increasing the understanding by the adult children of the etiology of their parent's behaviour.[1]

The therapeutic process was promoted by the development of a non-threatening milieu in which people experiencing similar concerns could ventilate and problem-solve. The most common theme expressed by most of the participants was that of mutual aid, or the process of engaging with others who were "in the same boat." As one member stated, "It's (the group) a most informative way of learning that you are not alone with your problems."

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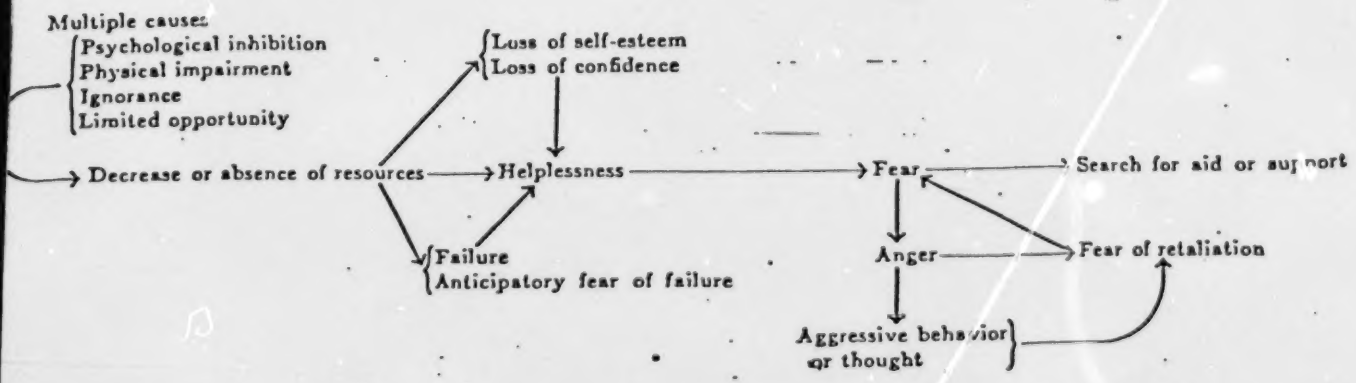
1. Goldfarb's outline of intrapsychic evolution of disturbed and disturbing behaviour in the aged.



After the first few sessions, members began to trust one another and felt safe in revealing their innermost feelings. By listening to others, members were able to learn alternate ways of dealing with their situation and coping with their emotions. Members could adopt those behaviours which were seen as potentially helpful to them.

The therapeutic value was obtained not only through the interaction amongst group members, but also by the interaction between the group and the therapists. The roles of the therapists included the provision of information, the focusing of discussion, the interpretation of feelings and behaviours, and the facilitation of sincere communication through empathy. One member felt that "the group leaders made me aware of my feelings without experiencing shame or guilt on my part, helping me to realize that I was one of a very similar group."

Evaluation:

For purposes of evaluation, a simple questionnaire was distributed to the participants in order to receive feedback as to the value and success of the program. Results indicated that all members found the group content educational and therapeutic. They felt that their knowledge of the aging process and understanding of the nature of their parent's behaviour had improved. On a functional level however, only 35% felt that they were better able to cope with the present situation. The rest of the members, although having benefitted from participation in the group stated that there was no perceivable change in their coping ability. It may be assumed that as long as the elderly person was in a vulnerable situation, and the adult child was responsible for maintaining

his parent, there would be minimal change in the coping behaviour of the child.

Summary & Conclusion:

Adult children experience great emotional stress when they must face up to the fact that they can no longer provide the care their parent needs. The realization that placement in an institution is the only alternative available to them often comes at a time when these children are coping with other internal and external pressures. It is necessary to recognize the upheaval these children are going through, and to provide them with supportive services during this time of filial crisis.

Due to the lengthy waiting period for admission to Maimonides Hospital and Home for the Aged, an innovative group work service program was developed to meet the psycho-social needs of these adult children of parents on the waiting list. The model of intervention combined a didactic and therapeutic approach in order to provide a supportive milieu for sharing and learning.

The program was deemed successful on these two levels and consequently, has become an integral part of the services offered by the Department of Social Work at Maimonides Hospital and Home for the Aged.

In conclusion, what is becoming more apparent as the aged population increases, is the deficit of services to the families of the elderly. Professionals must bridge the gap between needs and services to meet the challenge of helping these aging families. Practitioners in

general have not assumed an active role in helping children cope with the difficult situation they are confronted with in regard to their parents. To fulfil this task, persons in the helping professions must first increase their own level of awareness and knowledge associated with the aging process and secondly, must be prepared to deal directly and honestly with families presenting themselves for service.

References:

1. Blenkner, M., "Social Work and Family Relationship in Later Life with Some Thoughts on Filial Maturity." In E. Shanas and G.F. Streib (Eds.) Social Structure and the Family. Prentice-Hall, Englewood Cliffs, N.J.,1965, pp. 46-59.

2. Cath, S., "The Geriatric Patient and His Family: The Institutionalization of a Parent - A Nadir of Life." Journal of Geriatric Psychiatry, Vol. 5 (1): pp.25-51,1972

3. Goldfarb, A., "Geriatric Psychiatry." In A. Freedman & H. Kaplan (Eds.), Comprehensive Textbook of Psychiatry. The Williams & Wilkins Company, Baltimore, 1967, pp.1564-1587.

4. Kahn, B., and Silverman, A., "An Unmet Need: The other Generation Gap." Family Service Highlights, pp.2 - 4 (March-April 1976.)

5. Litwack, E.,"Extended Kin Relationships in an Industrial Democratic Society." In E. Shanas and G.F. Streib (Eds.), Social Structure and the Family. Prentice-Hall, Englewood Cliffs, N.J., 1965, pp. 290-323.

6. Shulman, L., "Program in Group Work: Another Look." In W. Schwartz and S. Zalba (Eds.) The Practice of Group Work. Columbia University Press, N.Y. 1971, pp. 221-240.

7. Sussman, M., "Relationships of Adult Children with Their Parents in the United States." In E. Shanas and G.F.Streib (Eds.), Social Structure and the Family. Prentice-Hall, Englewood Cliffs, N.J., 1965, pp. 62-92.

8. Issues and Ideas at Isabella. A Symposium on Attitudes: Fears and Guilts Surrounding Placing an Elderly Person in a Facility for the Aging. Isabella Geriatric Centre,New York.

A G E N D A

1. DESCRIPTION OF FACILITY

   A) FLOOR DESIGNATION

   B) WAITING LIST AND DEFERMENTS

   C) SERVICES OFFERED

   D) PRE-ADMISSION WORKUP

2) COMMUNITY RESOURCES

3) THE AGING PROCESS - GUEST SPEAKER: GERIATRICIAN

   A) PHYSICAL ASPECTS - DISEASES OF THE AGED

   B) PSYCHO-SOCIAL ASPECTS

   C) PSYCHIATRIC ASPECTS

   D) LEARNING TO COPE WITH PARENTAL BEHAVIOURS

4) INSTITUTIONALIZATION - PROS & CONS

   A) FILM -"HOW TO CREATE A NON PERSON"

   B) DISCUSSION PERIOD - FOCUSING ON FILM AS WELL AS MYTHS AND REALITIES OF INSTITUTIONALIZATION

5) FEELINGS & ATTITUDES

   A) EXPLORATION OF FEELINGS TOWARDS ONE'S PARENT, E.G. GUILT, RESENTMENT

   B) THE SANDWICHED GENERATION -PRIORITY SETTING
   C) THE ROLE OF THE FAMILY
   D) DEATH AND DYING

OBJECTIVES OF THE GROUP

1. TO INCREASE KNOWLEDGE OF THE AGING PROCESS, E.G. THE PSYCHO_SOCIAL AND PHYSIOLOGICAL ASPECTS:

2. TO FAMILIARIZE MEMBERS WITH RESOURCES IN THE COMMUNITY WHICH PROVIDE SERVICES FOR THE AGED:

3. TO HELP MEMBERS DIFFERENTIATE BETWEEN THE MYTHS AND REALITIES OF INSTITUTIONALIZATION;

4. TO SENSITIZE MEMBERS TO THE NEEDS AND BEHAVIOURS OF THEIR PARENTS;

5. TO PROVIDE A NON-THREATENING MILIEU WHERE MEMBERS COULD VENTILATE AND BE MUTUALLY SUPPORTIVE:

6. TO FACILITATE PROBLEM-SOLVING AROUND ISSUES INVOLVING THEMSELVES, THEIR FAMILIES AND THEIR PARENT;

7. TO DISCUSS THE ATTITUDES, COPING MECHANISMS AND EMOTIONAL RESPONSES OF THE PARTICIPANTS TO AMELIORATE THE INTER-GENERATIONAL RELATIONSHIPS;

8. TO FAMILIARIZE MEMBERS WITH THE INSTITUTION FOR WHICH THEIR PARENT WAS AWAITING PLACEMENT;

9. TO ALLOW MEMBERS TO SOCIALIZE INFORMALLY DURING THE EVENING'S COFFEE BREAKS.

INSTITUTIONS

CONS

1. LOSS OF INDEPENDENCE

2. REGIMENTATION

3. DEPERSONALIZATION

4. CARE PROVIDED BY STRANGER

5. ISOLATION

6. LOSS OF DIGNITY

INSTITUTIONS

PROS

1. PEER GROUP INTERACTION
2. STIMULATION THROUGH ACTIVITIES
3. MEDICAL ATTENTION
4. GOOD NURSING CARE
5. RELIEF OF PHYSICAL AND PSYCHOLOGICAL BURDEN
6. REHABILITATIVE SERVICES, e.g. PHYSIO AND OCCUPATIONAL THERAPY

THE AGING PROCESS - WHAT CONSTITUTES BECOMING OLD

Physical Change

- outwardly - loss of hair, graying hair

- elongation of nose and ears

- fat loss particularly around the face - skin wrinkles

- fading of eyesight and hearing

- postural changes - progressive structural decline that may result in a shortened trunk with comparitively long arms and legs

- within - loss of elasticity of tissues, muscles and vascular system

- cells diminish in number
- disappearance of cells of the nervous system
- less oxygen intake

Psychological Change

Physical changes trigger social and psychological reactions.

Some psychological manifestations of old age

- forgetfulness - decrease of memory for recent events, especially if the present is painful & the past was pleasurable

- self-assertive attitude - this is a compensation for a feeling of insecurity

- mild depression - caused by isolation, removal from employment, death of spouse, lonliness

- introversion - looking inward with longing and regret
- reminiscing - reflecting on good old days
- paranoid and suspicious attitudes

Psychological manifestations of old age are greatly influenced by the individual's degree of ADAPTABILITY. One's adaptability is measured by:

1) the capacity to profit from past experiences
2) the capacity to initiate new and more complex experiences

Emotional Change

- emotional changes due to lack of physical health

- loss - coping with loss takes up a great amount of physical and emotional energy

The emotional state of the aging person is affected by:

1) widowhood
2) marital problems
3) social problems
4) retirement
5) sensory loss
6) disease and pain

Social Change

- many face widowhood - more women than men
- older person is less involved in work and income related activities, and have more leisure time that they are not geared to doing anything with

- mandatory retirement, when many prefer to keep on working

- income for many becomes reduced and many are faced with poverty
- elderly men find themselves unprepared for finding life meaningful after retirement
- elderly women find it difficult to face widowhood after investing their total adult life into being wives and mothers
- many are deficient in social skills - making new friends

Society provides few supports and little encouragement. In many instances there is a negativism associated with aging.

Death

Death is a fact of life for everyone but its inevitable imminence is a fact with a difference for older people. Dealing with death means facing death as a daily fact. Is there fear or confidence, dread or hope? What is each individual finding in this closing of the life process and how is he using this part of life called death.

Organic Brain Syndrome

Brain Syndrome is the term applied to the group of measurable defects of mentation (brain functions) that reflect brain damage or dysfunction. When these deficiencies are transient, the condition is called acute and is thought to reflect reversible cerebral disturbance; when the deficiencies persist, despite adequate environmental and medical corrective measures, the condition is deemed chronic and is ascribed to brain damage. This condition, unfortunately is irreversible.

Signs of Brain Syndrome

1) disorientation for time, place or person-
2) evidence of impaired immediate recall-
3) deficits of recent and remote memory -
4) weakening of intellectual functions (e.g. errors in doing simple calculations or recalling simple general information)
5) defects of grasp and comprehension (e.g. difficulty in retaining and reacting to questions or commands; inappropriate responses to situations.)
6) intermittent or persistent occurences of the above.

The first 4 signs are diagnostic of brain syndrome. In chronic brain syndrome, one of these deficits is rarely found without the others, although some may be less obvious or severe than others.

Other signs may include emotional lability, speech defects, poor judgement and apathy.

Acute Brain Syndrome is usually related to an illness, infection, fractures, heart failure, drugs, and emotional overreactions. Blood count, chemical analysis, urinalysis and a physical examination will give clues to reversible disorder by revealing acute illness. With acute brain syndrome, there are fluctuations in the degree of disorientation, misinterpretations, and occasional hallucinatory phenomena. At times the disorder may be quiet, at other times it may be characterized by restlessness, helpless and bewildered confusion or a tendency to wander, both physically and verbally.

In almost all cases, the existence of acute brain syndrome may be taken as presumptive evidence of the simultaneous presence of developing chronic brain syndrome.

Chronic Brain Syndrome - By the time signs of Chronic Brain Syndrome begin to emerge, there is diffuse (widespread) brain damage. Some of the causes are assumed to be:-

1) Cerebral Arteriosclerosis - hardening of the arteries in the brain - strokes -- blood supply.

2) Senile brain changes (more common after age 70) may be introduced by emotional disorders or depression.

(shrinking of brain by deat of brain cells
(hemorrhaging
(metabolism - hormones - imbalance

With brain syndrome due to any cause, good education; high occupational and economic status and the early acquisition of socially acceptable patterns of behaviour tend to protect against troublesome behaviour. There may be excellent preservation of functions, especially on a social level, despite severe brain syndrome. Social behaviour may be so well preserved as to make severe memory deficit and orientation (e.g. "what did you eat for lunch today?"

"Don't worry whatever it was will tide me over until dinner time.")

Brain damage which leads to brin syndrome may be the result of genetically determined cerebral deterioration (heredity) or the result of vascular disease.

Classification of Chronic Brain Syndrome:

mild -- defects of general information are present - aware of person, time, place - but memory and orientation are relatively good (can still function in community)

moderate -- when calculation, memory and general information are impaired but orientation is fair or good (can still function) - aware of person but not time or place.

severe - when defects of orientation and of memory loss and intellectual function are obvious (need supervision and ultimately institutionalization.) Unaware of person, time and place.

Decrease of Resources - -- Failures in Mastery - tension, anxiety & frustration -

Decrease of - self-esteem, self-confidence - sense of purpose, sense of identity.

In rating the severity of Chronic Brain Syndrome, psychiatrists may be helped by 10 questions that test for orientation, memory and ability to do simple calculations. The questions are:

.....

1. where are we now?
2. where is this place located?
3. what is today's date, day of month?
4. what month is it?
5. what year is it?
6. how old are you?
7. when is your birthday?
8. what year were you born?
9. who is the Prime Minister of Canada
   " " " President of the U.S,
10. who was president before him?

Functional Disorders

1) Paranoia - "someone stole my money"
   " someone is out to get me"
   " ma has another man"

   treatment - drugs.

2) Affective r eaction -- manic depressive - more accentuated in old age.
3) Periods of aggression & violence.
4) Incontinence.
5) Speech defects.
6) Regression -- a) languages (mother-tongue) b) time (living in the past.)
7) Memory loss.
8. Anger towards family member most closely involved.
9. Wandering.
10. Undressing and overdressing.
11. Deterioration in self-awareness.

Treatment - Ideally, should include treatment of family as well as of the aged.

Alert -- best treatment is motivation and stimulation by -discussion - involvement - crafts, if interested - reading - listening to radio.

Confused -- orientation - audio & visual stimulation - small crafts.

A. GOLDFARB'S OUTLINE OF INTRAPSYCHIC EVOLUTION OF DISTURBED AND DISTURBING BEHAVIOUR IN THE AGED.